

# Giardiasis

\_\_\_\_\_

COUNTY

FOR STATE USE ONLY

#

- confirmed
- presumptive
- suspect

\_\_\_\_/\_\_\_\_/\_\_\_\_ case report

\_\_\_\_/\_\_\_\_/\_\_\_\_ interstate

Case Investigation is only required if:  the county's epidemic threshold has been exceeded; or  
 the case is part of an outbreak; or  
 the case is under age 4 and attends daycare/nursery school

Date investigation initiated \_\_\_\_\_

## CASE IDENTIFICATION

Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address \_\_\_\_\_  
Street City Zip

\_\_\_\_\_ email address \_\_\_\_\_

ALTERNATIVE CONTACT:  Parent  Spouse  Household Member  Friend  \_\_\_\_\_

Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
indicate home (H); work (W); message (M)

Address \_\_\_\_\_  
Street City Zip

## SOURCES OF REPORT (check all that apply)

- Lab  Infection Control Practitioner
- Physician  \_\_\_\_\_

Name \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first report)

Primary M.D. \_\_\_\_\_  
(if different)

Phone \_\_\_\_\_ OK to talk to patient?

## DEMOGRAPHICS

SEX  
 female  male

HISPANIC  yes  no  unknown

### RACE

- White  American Indian
- Black  Asian/Pacific Islander
- unknown  refused to answer
- other \_\_\_\_\_

Worksites/school/day care center \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
m d y

or, if unknown, AGE \_\_\_\_\_

Occupations/grade \_\_\_\_\_

## BASIS OF DIAGNOSIS

### CLINICAL DATA

Symptomatic:  yes  no  unk  
 if yes, ONSET on \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Check all that apply:  
 diarrhea  yes  no  unk

### LABORATORY DATA

Lab confirmed  yes  no  
 if yes, Lab \_\_\_\_\_  
 if no, number of stool specimens examined \_\_\_\_\_  
 Specimen:  stool  
 \_\_\_\_\_

### O & P RESULTS

- cysts
- trophozoites
- unk
- EIA positive

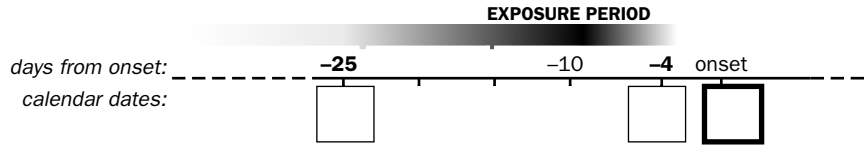
### EPI-LINKAGE

During the exposure period, was the patient...  
 associated with a known outbreak?  yes  no  unk  
 a close contact of a confirmed or presumptive case?  yes  no  unk  
 Has the above case been reported?  yes  not yet  
 Specify nature of contact:  
 household  sexual  daycare  \_\_\_\_\_  
 if yes to any question, specify relevant names, dates, places, etc:



**INFECTION TIMELINE**

Enter onset date in heavy box. Count back to figure the probable exposure period.



The communicable period is quite variable—weeks to months without treatment. Infected persons without symptoms are more likely to be infectious than those who are sick.

**POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD**

Skip this section if case is already epi-linked.

- no risk factors could be identified
- patient could not be interviewed

**POSSIBLE SOURCES:**

- yes no
- a   drinking untreated water (stream, etc.)
  - b   attends or works in daycare center/nursery
  - c   male homosexual contact

- d   contact with other people with diarrhea
- e   recreational water (pools, water slides, lakes,...)
- f   travel outside U.S. to \_\_\_\_\_
- g   other travel to \_\_\_\_\_
- h   recent arrival from overseas \_\_\_\_\_
- i   eating at restaurants
- j   eating at other gatherings (potlucks, events)
- k   \_\_\_\_\_

**SOURCE OF HOME WATER**

- unknown
- private source
- well
- surface \_\_\_\_\_
- public/community system
- name of company: \_\_\_\_\_
- \_\_\_\_\_

Provide details about possible sources and risk factors

**CONTACT MANAGEMENT AND FOLLOW-UP**

**HOUSEHOLD ROSTER**

name	age	occupation	diarrhea			onset date			education provided			comments
			yes	no	unk	m	d	y	yes	no	unk	
-----			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-----
-----			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-----
-----			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-----
-----			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-----

Does the case know about anyone else with a similar illness?  yes  no  could not be interviewed  
 if yes, give names, onset dates, contact information, and other details.

During the communicable period, did the case prepare food for any public or private gatherings?  yes  no if yes, provide details below.

If the case or household contact is a food handler, HCW with direct patient contact, or works at or attends daycare, provide details about site, job description, dates worked/attended during communicable period (if applicable), supervisor, etc.

Does the patient attend daycare or nursery school?  yes  no  
 If yes: Is the patient in diapers?  yes  no  
 Are other children or staff ill?  yes  no

**SUMMARY OF FOLLOW-UP AND COMMENTS.** Provide details as appropriate.

- hygiene education provided
- restaurant inspection
- work or daycare restriction for case
- \_\_\_\_\_
- daycare inspection



**ADMINISTRATION**

Remember to copy patient's name to the top of this page.

Completed by \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_ Case report sent to OHS on \_\_\_/\_\_\_/\_\_\_  
 Investigation sent to OHS on \_\_\_/\_\_\_/\_\_\_